Legislative Oversight Committee – MH/DD/SA

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Final Report & Gaps Analysis
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Preface
Overview Major Findings

- Mental Health & Substance Abuse Services are under funded, Developmental Disability Services are adequately funded.
- NC Over utilizes State Institutions.
- NC needs to increase treated prevalence for mental health and substance abuse.
- NC needs to increase continuity of care for mental health and substance abuse.

Preface

- The deliverables for both projects include a final written report and several complex statistical models. If state policy-makers disagree with the assumptions the consultants have outlined in this report, the models can be adjusted to
  - reflect different criteria;
  - modify assumptions;
  - run the models for a single county, group of counties, or on a statewide basis; and
  - to include or delete services.

Preface

- The Models incorporate prevalence assumptions
  - Prevalence data is universally not reliable
  - Prevalence data is not available for each population in the same format
  - Prevalence of conditions varies within subgroups of a population (such as rural vs. urban, economic class, ethnicity, etc.)
- Some measure for comparison to arrive at a Gaps Analysis is necessary
  - Used prevalence data felt to be most up to date and accurate
  - Adjusted data for population

Preface

- This is a complex undertaking with a huge number of variables
  - They are interdependent
  - Some can be derived from research
  - Some from DHHS Data files, and
  - Some is reliant on clinical judgment and experience

Methodology

- Created a Model calibrated to actual 2005 data
  - Claims data paid through May 2006 for service provided July 2004 - June 2005 (SFY2005) were utilized.
  - Service units purchased with local dollars are not reported
  - Funds allocated since 2005 are not included

Methodology

- Coding and service definitions
- Set of policy drivers
- Typology of operational definitions
- Specifications –
  - **2 payment sources (Medicaid and State General Revenues),**
  - **3 consumer disability categories (DD, MH and SA)**
  - **4 age groupings (0-18, 19-21, 22-64, 65+),**
  - **resulting in 24 (2X3X4) independent cohorts to be analyzed for utilization and cost information.**
  - **Organized by County**

Recipe

- Prevalence Rates are Applied to Population Data and Persons Served Annually to derive Treated Prevalence
- Values can come from historical data or be entered as prospective values under different assumptions of Service Intensity and/or Unit Costs
- Alternative Units
- Increase persons to be served in total, by Age or Disability Cohorts, or by County where populations are underserved.
- Use for one county or any groupings of counties to get LMEs, Regions or new geographical designations
- Increase or decrease payment rates by Payer (Medicaid or IPRS)
- Evaluate costs for bringing a new service online
- Examine gaps in service provision by County

Recipe

- **Prevalence**
- **Treated prevalence rates**
- **Population Growth**
- **Cost Per Unit of Service**
- **Annual Persons Served** (Increase or decrease)
- **Average Monthly Caseloads**

Recipe

- Cost of living,
- Additional services brought on line.
- Cost Assumptions for Medicaid or IPRS

- Added, Dropped or Substituted services
- Selectively increase or lower the number of service users &/or number of units per user &/or by Payer
- Projected potential reductions in use of State Facilities

Gaps

- **NC is above the national average in treated prevalence overall.**
- **The service amount and type are slightly higher than national averages for persons with DD, near average for children with SED and are below national averages for persons with mental illness and very low for persons with substance abuse disorders.**

Gaps
Continuity

- Most of NC is below average in treatment continuity for MH and SA.
- The Continuity Factor is a mechanism for determining how consistently each client is seen throughout the year. The closer the number is to 1, the more consistently the client was seen.

Gaps
Continuity

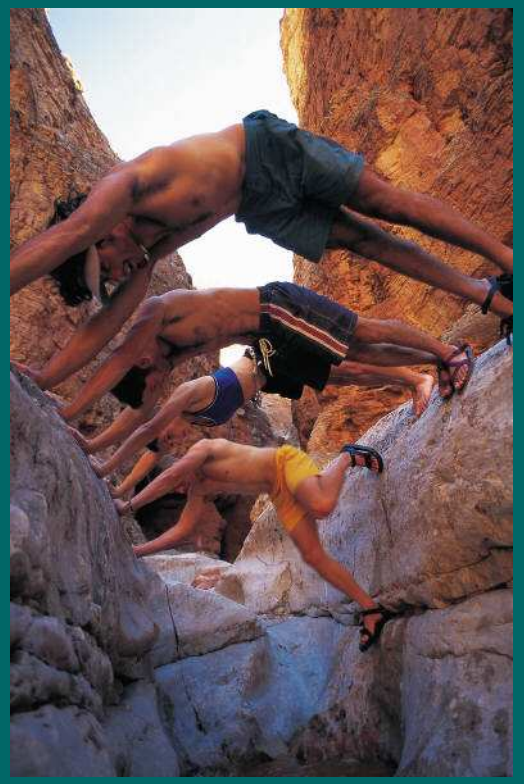
- Interruption of care, for whatever reason, is the most significant obstacle to establishing a stable recovery.
- Mental health - 55 counties below the statewide average of approximately 0.3. The factor for persons with SA is lower than MH.
- For adults with developmental disabilities 39 counties with a factor of .78 for continuity
- The statewide average continuity index is only around 0.2.

Gaps
Continuity

- Continuity - Spending less and serving more equates to not providing an adequate dose of care, which has a significant correlation with State Facility use.
- The major problem in NC at this time is that as demand increases, continuity of services - as measured by number of visits per year - is declining.
- Most significantly, services of all kinds are not available with the appropriate intensity and consistency to produce the outcomes this State desires in people's lives.

Gaps
Crisis Services

- The array and amount of crisis services throughout the state are not adequate to meet the needs of most individuals in the population.



Gaps
Crisis Services

- **The NC system is serving more people in hospital settings than the national average,**
- **NC needs to improve screening in the emergency room to identify alcohol or drug disorders and mental illness; strengthen linkages between the emergency room and the chemical dependency and mental health treatment systems to increase penetration rates, especially for alcohol or drug treatment**
- **People are often admitted to State Facilities in NC without earlier consideration of community-based alternatives.**
- **The array and amount of crisis services throughout the state are not adequate to meet the needs of most individuals in the population.**

Gaps
Crisis Services

- The advantages reported for such programs include
  - improved access to treatment,
  - the capability to avert a crisis or decrease its severity,
  - and reduced criminalization of persons with mental illness by diverting them from jail to treatment.
- Mobile crisis programs are a cost-effective service delivery strategy for
  - reducing the costs of psychiatric hospitalization,
  - Reducing family burden, and
  - Reducing the costs to the criminal justice system by providing professional assessment and crisis intervention where the consumer is.
- The State needs to change methods of reporting and require emergency service data on all encounters

Gaps
State Inpatient

- NC's per capita spending on community-based mental health is one of the lowest in the nation at $16.8 per capita
- While the national average percentage of expenditures spent on Inpatient Programs is 37.1 %, (median value = 42%) NC spent 65.5 % of total expenditures in this category.
  - State Hospital care is often provided as a first option rather than a last resort.
- The State Hospital admission rates in NC are 1.26 per 1000 population which places it number 50 among the states compared to the national average of 0.61 per 1000 persons.

Gaps
State Inpatient Diversion

- Increase pre-booking, post sentence, and probation diversion programs for adults and juveniles to reduce consumer trauma and corrections costs.
- Detoxification and Treatment Services are limited for assisting individuals with a history of substance abuse.

Gaps
Community Detoxification

- The provision of Community Detoxification services is negligible across the State.
- Nine out of ten aged and disabled consumers who visited the emergency room 3 or more times in FY 2002 had a substance abuse disorder, a mental illness, or both.
- The State should be interested in reducing community emergency room costs & MH/DD/SA State Hospital admissions and involvement of the corrections system.
- Discharge planning, including referral to the appropriate level of care, is an essential component of detoxification services. People are often admitted to State Facilities in NC without consideration for community based alternatives.

Gaps
Housing & Supported Employment

- Housing and supportive living arrangements for adults are not widely available throughout NC.
- The service benefit for all adults, including substance abuse, mental health and developmental disabilities is primarily lacking community integration, housing, supported employment and self-determination and/or recovery options that can in part be accomplished through transitioning to more independent and inclusive practices eliminating “programs” and large institutional settings.

Gaps
Culture Shift

- **A significant issue is the culture shift from traditional modes of practice to EBP, recovery technologies, empowerment and resiliency strategies.**
- **Training and the involvement of consumers in training and as peer supports is critical.**
- **The State has not used peer supports or consumer owned or operated programs.**
  - These efforts have been found to reduce the cost of care, but more importantly to result in consumer's development of a sense of empowerment that leads to their recovery.

Gaps
Culture Shift

- The Consumer is not being vested with credibility or involved in designing the system in real ways

Gaps
Capacity

- **At this point it isn't possible to know with any certainty which services an LME has or doesn't have – local and emergency services are not reported.**
- **When services have high unit cost but low utilization they meet the criteria to be candidates for cross-over or shared services.**

GAPS
Center Based Service

- The service array is over reliant on facility or bed based services, out-of-home placements, traditional outpatient therapies, and relatively long term “day-type” programming and other “center-based services”.
- There is resistance to mobile service

Gaps
ACTT

- ACTT program. Treated prevalence is 0.3%. In reviewing data from states with less state facility use than NC, one would expect rates in the range of 1.5 to 2.5 per 1000 treated prevalence which is closer to the two counties identified as positive outliers for ACTT in NC.

Gaps
Other

- **Clients living in densely populated areas are receiving many more EBP services than clients living in rural, less dense areas.**
- **The data show that NC is below the national average and the Southern Regional average for serving the elderly.**
- **The system needs to introduce methodology to more successfully engage consumers in their individual recovery plan, especially those in rural areas and people over 65.**

Policy

- To implement a strong system the State must provide leadership with clear and enforceable policy parameters that are communicated through administrative rules and contracts. The State should establish community policy positions in Rule which will promote enforceable equity and quality system wide.

Policy & State Institutions

- Restrictive Care
- Principal Agent Conflict
- Community Inpatient
- Inpatient Funding & Incentives
- Care Coordination

Policy
Restrictive Care

- Least restrictive care and Single entry to restrictive care must be enforced to reduce the inappropriate utilization of hospitalization.
- Transfer (on some basis to be determined) State facility dollars (or provide seed money for expanded community programs) to area programs and hold them responsible for authorizing and purchasing state inpatient care.
- Decertify ICFMR and transfer dollars to local LME for community living programs.
- Provide only the therapeutic care in residential settings based on level of need.
- Implement more in-home programs and at certain LOC require in home services before placement and parent participation while in placement.
- Require transitional in-home services as a mechanism for returning a child already in residential care to the home environment.
- Utilize ADATCS for SA and reduce access to psychiatric inpatient care until the SA crisis has abated and there is evidence of a clear mental health condition requiring hospitalization.
- Establish the authority with LMEs for the State hospital front door

Policy
Principal Agent Conflict

- **If the State does not downsize hospitals as part of the process and create a system for control of state facility admissions (or payment for admissions) those with "principal agent" conflicts will continue to fill beds and the costs will continue to grow.**

Policy
Community Inpatient

- Community Inpatient staff are sending people to State Facilities without the LME having a chance to offer an alternative plan.
- People with substance abuse problems constitute the primary reason for increased numbers of admissions to the State hospitals
- The data submitted to TEDS and State claims data do not agree in terms of the number of people with SA admitted to state facilities. This is probably due to the way diagnoses are entered in the data system. This needs to be examined closely.

Policy
Funding

- There are no current incentives to either prevent admissions or to get people out of the hospital or centers.
- The State needs to develop a process for placing the management and financing of consumer care solely with the LME. This course of action would give LMEs full financial and clinical responsibility and accountability for their citizens.

Policy
Care Coordination

- Local LMEs are not in a position to coordinate and manage services through a preferred network, thereby presiding over a fragmented system design that does not allow for capacity/efficiency analyses or for good coordination of care.

Policy
Care Coordination

- There is currently no statewide mechanism for LMEs or other primary service providers to know when persons in their care enter a crisis state or emergency services setting.
- This lack of information results in poorer care than desired, frequent hospitalization, and less care coordination.
- NC Needs to improve screening in the emergency room

Policy
Fidelity

- **A specific process should be outlined for program start-up that requires a Supervisory person to receive training prior to application for the remainder of the program start-up.**

Policy
Best Practices

- Implement the Supported Employment Model
- Implement Community integration in real settings.
- Increase supported employment efforts
- Increase affordable and independent housing supports for adult populations
- Increase Peer Supported/operated services.
- Implement inclusive service settings for children.
- ACT should be expanded to prevent hospitalization.
- Treatment or supports that are not covered in the state plan will not be provided, except in unusual circumstances.
- The State and LMEs should reduce treatment variations that are based on preferences, rather than their demonstrated effects on treatment outcomes.

Policy
Coordination of Benefits

- The State needs administrative rules that clearly set enforceable coordination of benefits policy at the local level so that private insurance is routinely billed before public dollars are expended and people that are not eligible for Medicaid are assessed for their ability-to-pay with strong efforts to collect reimbursements.

Policy
Statewide Assessment

- The State shall move toward a Standardized assessment to ensure state-wideness of eligibility determination

Policy
Monitoring & Oversight

- **MH transformation requires an increase in Division monitoring and technical assistance which cannot be effectively pursued with current levels of staff.**
  - **Monitoring state hospital downsizing**
  - **Handling Appeals and Grievances**
  - **Providing support for a cultural shift from traditional modes of practice to EBP in the field**
  - **Developing and training a cadre of competent consumers**
  - **Monitoring data including continuity and access measures**
  - **Providing assistance/consultation for Program Start-up**
  - **Monitoring new programs and measuring fidelity to standards**
  - **Monitoring the phasing out of non-EBP programs**
  - **Performing UM review of select State Hospital admissions to determine if admission was a first option rather than a last resort.**
  - **Research and apply for waiver opportunities**
  - **Develop and implement rules as approved**
  - **Complete routine and scheduled LME reviews**
  - **Provide leadership versus crisis management**
  - **Conduct a system review to evaluate roles of each player in the system and clarify those roles and responsibilities to prevent rework**

Policy
Outcome Data

- The LME Contract needs performance indicators, a requirement for services capacity reporting, and reporting of all service units regardless of payer.
- Benchmarks are not currently available for expected performance in some areas. Of particular importance are indicators measuring :
  - New persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service. (95%)
  - New persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional (95%)
  - The percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days (95%)
  - The percent of discharges from a substance abuse detoxification unit who are seen for follow-up care within seven days.(95%)

Funding Resources

- New Resources:
  - State Facility Reduction: 25,103,373*
  - Community Medicaid Increase (26.8% new clients): 12,133,798 Federal Share
  - Ability to Pay (10%) – 23,487,213
  - Room & Board – 39,883,360 (13m ICFMR)

Funding
Augmented Medicaid Benefit

- The Medicaid benefit is frequently augmented with other funding. This often has the effect of making a “rich” benefit, “richer” and takes from the pool of resources needed to support the non-Medicaid population.
- Many of these augmentative services are not evidence-based practices and yet there is considerable political pressure to hang on to them.

Funding
Increasing Medicaid Eligibles

- NC needs to consider the Independence Plus Waiver and a Medicaid Buy-In to implement increased levels of employment.
- Those living below 100% of the Federal Poverty Level exceed the national average by 3%. This means that comparatively more people are potentially eligible for Medicaid.

Funding
Reduce Cost & Limit Provider System

- The system is growing in a free market way without planned attempts to assure services are available and adequate throughout all parts of the State.
- This will ultimately result in failed provider systems and providers who refuse to treat the indigent population.
- Seek a Medicaid waiver to allow limitations on who can be providers.
- Explore the possibility of a relatively straightforward 1915 (b) waiver to allow regional structures to be funded with Medicaid dollars and to have these structures manage the provider network and the service delivery process.

Funding
Coordination of Benefits

- Monitor 1st and third party receipts at Area Authorities to increase system revenues or hold the State harmless for an expected collection.
- Require parents to use child SSI funds to pay for room and board or purchase room and board out of pocket.
- Legislate statewide ability to pay Schedule and collection requirements based on NC taxable income and number of dependents.

Funding
Coordination of Benefits

- Monitor the extent to which people are assisted in gaining entitlements and other resources that assist in paying for their care.
- Reduce the amount of time consumers are removed from Medicaid unnecessarily by evaluating mechanisms for Spend down to avoid consumers losing services.

Funding
Equitable Allocation

- The State of NC is faced with a historical funding base that is not equitably distributed leaving some counties with greater need relatively under funded.
- Services cannot be equitably applied statewide as long as this allocation process continues.
- The allocation model will help to resolve this issue by narrowing the gaps between richer and poorer areas.

Funding Alignment

- NC has an opportunity to align finances, quality, and care management in a single structure.
- Alignment must include ICFMR and State Inpatient dollars making them available for redirection.

Total Impact

- The collective impact of Long Range Planning changes on total system-wide costs to bring the NC MH/DD/SA system to treated prevalence rates at the national average, to downsize state facilities, and implement new evidence based practice, to sustain population growth and the economic increases the system is currently facing and to implement strong levels of continuity of care will be 2.7billion dollars.

- In order to reasonably plan for system improvement the legislature must decide what can "reasonably be managed over the ensuing five year period," must have a priority for the changes it desires starting first with those things that save resources and promote good care. This means tough policy decisions, including passing legislation where necessary.

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